Better Life Care Ltd

Better Life Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service:
• The service's office is based in the Slough central business district. Care is provided in the surrounding areas.
• The service provides personal care to adults with complex needs, some of whom have dementia.
• This is the only location that the provider operates.
• At the time of our inspection, six people used the service and there were 14 staff.

People's experience of using this service:
• The provider had made some improvements to the service since our last inspection.
• Staff received better training, induction, supervision and support so they could effectively perform their roles.
• The service had assessed people's care risks in a more detailed way and had better plans in place to mitigate the risks.
• There were safer recruitment practices in place to ensure that only fit and proper staff were employed to provide care or support the service.
• Relatives told us the staff were kind, friendly and dedicated. They said staff knew people's needs well.
• Governance of the service requires improvement. Insufficient checks and audits are carried out to determine the quality of the care. The provider had failed to act on some areas already identified for improvement.
• The provider sought professional assistance to achieve compliance with the regulations. The provider had delayed seeking this support and as such, has neither implemented nor sustained all the necessary changes to ensure a good service.
• A competent staff member who can satisfactorily lead the service and ensure safe care with good governance must register as the manager with us. This is a condition of the provider's registration.
• The service met the characteristics for a rating of "good" in all the key questions we inspected, except for well-led. The rating for well-led remained at "requires improvement". The overall rating for the service remained at "requires improvement" because of a continued breach of a regulation.
• More information is in our full report.

Rating at last inspection:
• At our last inspection, the service was rated "requires improvement". Our last report was published on 8 September 2018.

Why we inspected:
• All services rated "requires improvement" are re-inspected within one year of our prior inspection.
• This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow-up:

• The service will be required to submit an action plan to us setting out how they will achieve a rating of at least "good".
• We will assess the current application for the manager to register with us and make a decision.
• We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our findings below.	**Good**
Is the service effective? The service was effective. Details are in our findings below.	**Good**
Is the service caring? The service was caring. Details are in our findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our findings below.	**Requires Improvement**

Better Life Care

Detailed findings

Background to this inspection

The inspection:
• We carried out our inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Our inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
• Our inspection was completed by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had knowledge about personal care of adults within the community.

Service and service type:
• This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to children, adults and people with dementia. At the time of our inspection, six adults used the service.
• The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection, there was no manager registered with us. A staff member had applied to register, and their application was being processed by us.

Notice of inspection:
• Our inspection was announced.
• We gave the service 48 hours' notice of the inspection visit because the manager was often out of the office supporting staff or providing care. We needed to be sure that they would be available.

What we did:
• Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We

checked records held by Companies House and the Information Commissioner's Office (ICO).
• We asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
• We spoke with five relatives of people who used the service. We were unable to speak with people themselves.
• We spoke with the nominated individual, manager, care coordinator, one care worker and a compliance consultant.
• We reviewed six people's care records, two personnel files, audits and other records about the management of the service.
• We requested additional evidence to be sent to us. This was received and the information was used as part of our inspection.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At our last inspection on 7 August and 8 August 2017, this key question was rated "requires improvement". We found people were not always satisfactorily protected from identified risks, there were unsatisfactory recruitment practices and staff medicines competencies were not completed. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the service had taken steps to improve the safety of people's care. Therefore, the rating for this key question has increased to "good". Further improvements to ensure people's safety are ongoing.

People were safe and protected from avoidable harm. Legal requirements were met.

Staffing and recruitment:
• The service had improved recruitment checks since our last inspection.
• There were satisfactory employment processes in place to ensure fit and proper person were employed to provide care and support to people and the service
• We checked two personnel files. They contained all the necessary checks and documents to ensure fit and proper persons were employed. This included ID checks, a criminal history check, full employment history, checks of conduct (references), qualifications, health questionnaire and interview notes.
• Five people who used the service had specific care workers who provided their care. One person had different care workers and received a weekly list of who would complete their calls. Continuity of care was provided by having, as far as possible, the same care workers attend care calls for people.
• The nominated individual told us staff deployment was based on people's dependency levels.
• Staffing levels increased or decreased in line with the number of people who used the service at any given time.
• Care calls were clearly documented in the care folder and electronic record system.
• Care call duration was based on the needs of the person. For example, when a person required bathing or showering the amount of time for care workers was adjusted to allow the support to be completed safely.
• An electronic system was used to monitor the timing of the calls, and whether they were early, on time or late. With the number of people who used the service, the nominated individual said it was, "…easy to oversee what the care workers are doing."
• Relatives said, "They come on time and they go on time. They have never missed a visit. I call them if I need to cancel a visit and the message always gets through" and "There is a rota of carers and they are introducing another one so they are covered. They are very good at being on time and if for any reason they are going to be late they let me know."

Assessing risk, safety monitoring and management:
• The provider had acted on the items we highlighted in our prior inspection report.
• Staff completed an initial assessment of people's needs. They asked for relevant documentation from the local authority or other commissioner.

• The service assessed each person's risks and the capacity to deploy appropriate numbers of care workers to support people.
• The service visited people in their home or other settings like hospitals. They spoke with the person and relatives, or another responsible person to gather information about risks.
• A risk assessment was completed to determine what the person's needs were and what support they required.
• The risk assessments covered topics like medicines, the person's functional ability, communication needs, risks in the home environment and equipment the person needed.
• The care documentation set out the risks and control measures in place to mitigate the risks. For example, one person's risks were related to falling out of bed. The care records showed that the person had bed rails in place and that care workers were to check these at any calls where the person was left in the bed at the end of the visit.
• There was a business continuity plan in place which set out how the delivery of care would continue during unplanned events, for example adverse weather or failure of utilities.

Systems and processes:
• People were protected from the risks of harm, abuse and discrimination.
• There was a safeguarding and whistleblowing policy in place which set out the types of abuse, how to raise referrals to local authorities and the expectations of staff.
• There were contact details for the relevant authorities in different folders.
• Staff completed safeguarding training to provide them with the knowledge of abuse and neglect. This included online training and face-to-face training.
• The nominated individual explained there were no safeguarding referrals since our last inspection, however they knew how to report relevant matters.
• Relatives said, "My daughter has complex needs and they do work well with her generally but I've [provided instructions to] them. I do however feel she is safe with them. They cover her up and tell me if it gets too hot as she has seizures. If she does have a seizure they look after her and they time the seizure which I have asked them to do" and "I do feel she is safe. If there is anything unusual they will call me and they always check things with me first. They put me and [the person] first."

Using medicines safely:
• Continued improvement of medicines safety was required.
• Some people did not require medicine and others had relatives administering their medicines.
• There were paper and electronic medicines administration records (MARs) in place. They contained most of the information required for safe medicines management but did not show some of the important aspects. For example, there was no place to record allergies, although this was within the electronic care record.
• Some other documents for medicines management were not in place. For example, there were no charts for the recording of creams and lotions in place. There were no 'as required' medicines protocols in place. Not all staff had completed medicines competencies.
• We spoke with the provider's consultant who showed us a range of mechanisms being put in place to ensure people's safety. For example, there was a plan for a separate 'as required' MAR form and protocols to be implemented. There was also a plan for new MARs for morning, lunchtime, evening and tea time calls. This would ensure better documentation of medicines administration.
• There was an alleged incident with one person's medicine. When this was raised, the manager visited the person's house to speak with a relative. The manager assessed what the allegation was but it was not possible to substantiate the alleged incident. The manager agreed with the relative that both care workers who supported the person would administer the medicines together. This would help prevent any further incidents with the person's medicines.

• Medicines incidents were not documented on a particular form. However, the manager had made notes of the alleged incident above and the actions they had taken in response.
• Some staff had medicines competency assessments. One we viewed was completed by the manager observing the care worker's practice as well as checking their training records. There were plans to repeat the medicines competency assessments.

Preventing and controlling infection:
• Staff completed training in infection prevention and control. They are required to repeat the training annually to refresh their knowledge.
• Staff had access to personal protective equipment such as gloves, aprons and shoe covers. They had access to handwashing facilities and alcohol-based hand rub for disinfecting their hands.
• Staff were required to complete training in food hygiene, so that they could safely make and serve meals and clean up after preparation.

Learning lessons when things go wrong:
• There were no recorded accidents or incidents since our last inspection, although a medicine incident was documented in a different manner.
• There were appropriate forms in place for use for recording accidents and incidents.
• If there was an accident or incident that involved a person, care workers were aware to call the office or the on-call manager to report the issue. Notes would then be recorded in the electronic care records.
• As there were no recorded accidents or incidents, there were no themes or trends that could be identified. The provider had systems in place however for analysing any accidents or incidents reported.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At our last inspection on 7 August and 8 August 2017, this key question was rated "requires improvement". We found there was no formal induction programme for new staff, there was no system in place to gauge the effectiveness of staff training and staff did not receive sufficient supervision sessions. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the service had taken steps to improve the effectiveness of people's care. Therefore, the rating for this key question has increased to "good". Further improvements to ensure effective care are required.

People's outcomes were good, and relatives' feedback confirmed this.

Staff skills, knowledge and experience:
• The management team had acted to improve staff knowledge and skills since our last inspection.
• Most relatives felt that the staff had the skills and knowledge to support them.
• Improvements to the staff induction, training and supervision of staff were noted. Staff completed the Care Certificate; a nationally-recognised set of 15 learning standards for new workers to complete.
• Staff had completed a satisfactory induction and were provided the opportunity for supervisions and appraisals. One-to-ones were held more often, and appraisals had commenced.
• A care worker told us they had the necessary training to perform their role. This included how to administer artificial feeds using a pump, manual handling, first aid, medication and fire safety. The care worker confirmed that they participated in supervision sessions every quarter with the manager or care coordinator. The care worker said they found the supervision sessions helpful to their role.
• Training certificates and qualifications were within staff personnel files. Some staff were completing different levels of diplomas in social care.
• The training matrix we received after the inspection showed staff completed a range of training. Staff training was up-to-date. The nominated individual explained how often each topic was completed, and the method for the training. A mixture of training types was used, including e-learning, face-to-face training and workbooks.
• A relative said, "They do mention training. They will say 'so and so is not coming because they have training' and so they try to send somebody who knows my daughter."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People's preferences, likes and dislikes were assessed and recorded in the electronic care system.
• Following an enquiry about care, the care coordinator and manager visited the potential client. The staff took a tablet computer with them, which displayed all the necessary forms.
• Assessments of people's needs were undertaken, expected outcomes were identified and care and support was regularly reviewed. Assessments also included the copying and retention of any other health or social care professionals' notes.

• In one person's electronic care record, we saw all sections were completed.
• The "social activities" and "social inclusion" sections recorded important cultural and religious requirements. We saw the person liked to listen to recordings related to their chosen faith.
• The care documentation included risk assessments as well as detailed instructions for morning, weekend and evening visits, social outings and a privacy statement.
• The person could not sign the record themselves, but it was agreed between the manager, care coordinator and relative. There was a note that this was the best planned care and support that could be put in place.
• Staff accessed the care records via a mobile phone application. The service advised the care workers to rely on the printed plan in people's homes if there was a poor mobile phone signal. This meant staff had access to people's recorded needs and choices if they were required to check something.

Supporting people to eat and drink enough with choice in a balanced diet:
• People were supported to eat and drink enough.
• For example, nutrition guidelines were in place where the person needed support in this area.
• Communication guidelines, where needed, advised care workers how people demonstrated they would like something to eat or drink.
• Care workers had received necessary training, for example in artificial feeding using a pump.

Staff working with other agencies to provide consistent, effective, timely care:
• The service worked with other agencies and professionals to ensure people received effective care.
• Where people required support from other professionals this was supported and staff followed guidance provided by such professionals. Information was shared with other agencies if people needed to access other services such as hospitals.
• A relative said, "I get help in the weekdays but really need help at the weekends. A staff member] has spoken on my behalf to the council to increase the care, but we have not got anywhere yet. She is trying."

Supporting people to live healthier lives, access healthcare services and support
• Where necessary, the service support people and relatives with healthcare appointments and reviews.
• The staff were aware of any feedback from health and social care professionals. There was evidence that information from other agencies was included in the electronic care records.
• Where people had complex care needs, for example artificial feeding via a pump, the care workers and management liaised with the relevant healthcare worker for advice or support.
• The staff ensured necessary equipment and supplies for complex care were obtained and appropriately used.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

• Staff assumed people had the capacity to make decisions, unless they assessed otherwise. Some people who used the service lacked the capacity to consent to care and treatment.
• There was evidence of mental capacity assessments, when needed, and their outcomes.
• Other people had capacity to consent to their package of care, but were physically unable to sign consent documentation. On these occasions, the records clearly showed that the person consented, but was not

able to sign the document.
• Staff received training in the principles of the MCA and how to apply it during the provision of care calls. A care worker we spoke with could clearly explain how they applied the principles of the MCA to their role, and the responsibilities required.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported:
• The service provided kind, compassionate care. Care workers were friendly and knew people well.
• Relatives provided positive feedback. They told us that when they had concerns, care workers or the management team usually acted promptly on them.
• A relative commented, "They are doing a good job, so far so good. They help me with many things. If I am struggling I call them and they come to help me. They are so kind. For example, the stairlift broke about two weeks ago and I spoke to the carer and she called the company and got it fixed quickly. They are so kind and respectful to my son and to me. They talk to him and to me. Until they took over I was struggling, but now I'm much more relaxed. They are always there for me."
• One relative provided feedback to us about social interaction with a person who used the service. We provided the information to the management team about this. They provided reassurance they would contact the relative and discuss the matter to reach a more positive outcome.
• The service demonstrated a clear commitment to the care of people, but also the welfare of relatives and caregivers.
• One relative said, "They are genuine and think about the parents too. They treat my daughter like a normal human being, which is lovely. They talk to her and will say things like 'We are just about to change you. They have built a lovely rapport over time. They never talk about other people they visit when they come to us. They touch my heart. They really care and are not just in it for the money. They will say 'If you are feeling down then come and talk to us'. I trust them to be with my girl and they always make her look so beautiful. I am so happy I found them. They make my life so much easier with their support."

Supporting people to express their views and be involved in making decisions about their care:
• There was clear continued evidence within the electronic care records that people and their relatives were involved in care planning and reviews.
• The care records showed how often care plans were reviewed. A version number was recorded in the person's file. For example, we saw frequent reviews of the care for two people, where the care plans were versions 31 and 64. This meant the care plans were frequently reviewed.
• All the care plans were last reviewed in November 2018, which meant they were up to date.
A relative told us, "There is nothing that could be improved. We are very happy. We don't have to ask them anything. They just get on with cleaning, washing and listening to her needs."
• Other comments included, "They came out and reviewed the care plan. There was nothing much changed but we did feel that they listened to us", "They document everything and they call a review every so often" and "They come out and go through my son's care plan every two to three months. They make sure they listen carefully to us."

Respecting and promoting people's privacy, dignity and independence:
• Staff we spoke with told us about their responsibility to ensure people's rights were upheld and that they were not discriminated against in any way.
• Staff gave us examples of working well with people and relatives to provide care in a respectful way. Relatives commented on the nationality of the care workers, but explained this was not a barrier to the care practices.
• People received dignified care. For example, a relative said, "With them [the staff], she is always calm and relaxed. They also ask my wife how she is too. They are very respectful of my daughter [who used the service]. They talk to her calmly and they will make sure they show her respect. For example, they cover her with a big towel when they are washing her…very, very good."
• All care workers were female staff members. The management team explained there was the ability to provide gender-specific care if requested, as the nominated individual could also complete personal care. The nominated individual explained that male care workers could be recruited if the need arose.
• Confidential personal information was accessed and stored correctly by the management team. This ensured the privacy of people's and staff's records.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs

People's needs were met through good organisation and delivery of care.

The provision of accessible information:
All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.

• The care records documented that the service identified and recorded communication impairments, and steps were implemented to ensure information was provided to people in a way they could understand it.
• Some people had very complex needs, and staff recognised the need for alternative methods of communication with them.
• Care documentation explained what communication aids such as glasses, hearing aids or sign language people required as part of their daily lives.
• A relative told us, "They are very lovely girls [care workers]. They talk and chat to her [the person], even though we are not sure how much she knows. They give her the benefit of the doubt and include her in the conversation. She [the person] uses gestures to communicate and they [staff] are able to interpret what she means, as they have got to know her."

Personalised care:
• People received personalised care responsive to their needs. What was important to people and relatives and what they aspired to was considered in the needs assessment and care planning process.
• Care workers got to know the people well, to spend time with them and provide personal care in a pleasant and happy way.
• People had a care planning folder kept in their own home, accessible to all healthcare professionals. Care plans included physical, mental and social needs, and any tasks which needed to be completed on visits.
• Staff knew and understood people's likes, dislikes and preferences, and used this knowledge to care for people in the way they wanted.
• Most relatives stated that the service was flexible and able to provide extra help when a person or they needed it. For example, a relative commented, "They are good at covering. For example, my own mum has been very ill recently and they were able to increase the hours for my daughter to support me."
• Another relative said, "We don't have carers on a Wednesday, but if I do need their help I call them and they send someone out. It's very good. They don't even charge me, they just do it." This was a good example of responsive care.
• Scheduled care visits could be readily changed by relatives in consultation with the service. The service could adapt to people's changing needs.
• A relative told us of examples of this. They said, "We rarely have to phone the office, but can always get through…a couple of times we have had to change the schedule because of appointments and that has not

been a problem. Sometimes we ask for an earlier visit, if she [the person] has an early hospital appointment and they always come on time and get her ready for the appointment."
• Relatives explained that they sometimes educated care workers about how to carefully provide personal care in the right way. The staff also helped relatives in difficult situations. For example, one stated to us, "They [staff] give me tips and advice such as on best ways of dressing her. They have also helped me when she has had fits and they have stayed with me until the ambulance arrives. They use a hoist with her and they are very, very careful and check each other all the time. I feel confident in them. They seem to understand about complex needs."

Improving care quality in response to complaints or concerns:
• The management of any concerns and complaints received by the service required further improvement, although there were changes since our last inspection.
• The provider had set up a system for responding to complaints and for recording complaints, outcomes and actions taken in response to complaints. The provider had not received any complaints in the last 12 months.
• The provider recorded any feedback, in electronic care records, but did not clearly separate operational issues from concerns and complaints .
• People who used the service, and their families, knew how to provide feedback about their experiences of care, and the service provided a range of accessible ways for this to be done.
• People and relatives knew how to raise concerns or make more formal complaints should they need to.
• All five relatives we spoke with told us they had never raised a formal complaint. Two explained on limited occasions, they had communicated an issue with the management and this was not resolved to their satisfaction. The nominated individual explained the actions they would take about this following our site visit.
• One relative stated, "If I am not sure or unhappy about anything they address it straight away. I had an issue before, in the early days, with the carers as they were talking to each other in their own language but I've spoken to [the manager] and it was addressed straight away and has stopped. Quite often they [the service] will ring to see if I'm happy and we resolve any minor issues between us."
• A further relative stated, "We have not had to complain about anything but I do feel any concerns would be taken seriously. [The manager] is the 'boss'. [They] called me a few days ago to ask how things are going and she always phones back if I leave a message. [The care coordinator] calls from time to time and checks whether there is anything we are not happy about. They are all very nice and helpful."

End of life care and support:
• No one received end of life care or support at the time of our inspection.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care, supported learning and innovation and promoted an open, fair culture

At our last inspection on 7 August and 8 August 2017, this key question was rated "requires improvement". We found there were no effective systems in place to assess, monitor and improve the quality of the service being provided. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the provider had taken a small number of steps to improve the governance of the service. More work on the governance of the service was required. Therefore, the rating for this key question remains at "requires improvement".

Service management and leadership was inconsistent. Leaders did not always support the delivery of high-quality, person-centred care.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements:

- The previous manager deregistered in February 2018 and the new manager commenced an application to register in August 2018. At the time of the inspection, their application was being assessed by our registration team. The service is required to have a registered manager as part of their conditions of registration.
- The manager possessed sufficient operational and practical knowledge at service level, to ensure the day-to-day provision of people's personal care.
- However, the manager did not have sufficient operational experience in the adult social care sector. We provided this feedback to the management team at our site visit. The manager had, however, completed a managerial-level diploma in 2017.
- We asked whether the manager had commenced a relevant qualification to upskill them and enhance their understanding of regulation, safety and governance. They had not started a relevant diploma or other course. We suggested the manager explored gaining further training in leadership and governance.
- The manager was well-liked by the staff and interacted positively with them.
- The care coordinator was skilled, knowledgeable and able to explain all aspects of the service. They were approachable and staff had a good working relationship with them.
- The compliance consultant held a meeting with the provider and manager in November 2018 to set out the expectations of management meetings. Items discussed included ownership and responsibility of roles, accountability, file audits, policies and procedures, staffing and peer group (staff) meetings.
- Due to the number of staff employed, meetings were not routinely held. Instead the manager and provider communicated regularly with staff via telephone and e-mail. Staff also had regular feedback and discussions with the manager and provider during one-to-one sessions and performance appraisals.
- Management meetings were held each week, although records of the meetings were not kept prior to the appointment of the compliance consultant. After the appointment of the consultant, the topics of the management meetings was being recorded in minutes.

• Standing agenda items in the management meeting included on-call updates, "client" requirements, staff requirements, complaints and compliments, medication, documentation and any other business.
• The service had recorded brief information. For example, one set of meeting minutes stated, "[The relative] rang to ask for one specific carer today." In another week, it was noted that a person had called to provide positive feedback. The record stated, "[The person] complimented verbally and said [they] were happy with the services we gave him." There was no indication of how this information was shared with the care workers.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong:
• The service had an appropriate statement of purpose. This clearly set out the aims, objectives and ethos of the service. The statement of purpose was available for anyone to access and read.
• Objectives of the service included, "To provide personal and practical care" and "To assist service users to achieve and maintain their independence."
• There was a "service user's handbook" in each person's house. This contained important information such as who the person's key worker was, how people's confidentiality was maintained, the availability of advocates and various contact details,
• Each person or their relative was given a copy of the commencement of the care package. They were asked to sign a "receipt form" to acknowledge they had received a copy and were aware of the content.
• The provider contracted a compliance consultant in 2018; however, their deployment at the service was only shortly before our inspection. They were present at our site visit, and demonstrated areas for improvement to us. Some tools and processes had started to be used by the management, whilst others were planned for implementation.
• The provider had not act promptly enough to implement systems to ensure good governance of the service. There was evidence of a small number of audits completed in the prior three months to our site visit. At our inspection there was evidence audits were not sufficiently embedded, gathered usable key performance data and led to improvements that were sustained over time.
• Documentation still required improvement to ensure it was in line with the regulation. For example, the staff training matrix was not accurate at our site visit although staff had the necessary training for their roles.
• This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff:
• The service engaged with people and relatives in a positive manner.
• People or their representatives were asked for feedback. A survey was sent to six people or their relatives in May 2018. Five responses were received.
• The manager completed an analysis of the results. They also sent a letter and copy of the results to all people who used the service. This included what the service would do to improve.
• The respondents demonstrated they were satisfied with various aspects of the care, including the attitude of staff, respect of people's preferences, the provision of information, support from the office staff and the number of staff deployed.
• From the results, the service identified the three main things they determined needed improvement. These included improvement of the way care workers "do things", improvement in care workers' training and updating the service user guide, contracts and other relevant information.
• An updated, more comprehensive version of the survey was to be distributed to people and relatives in December 2018. The survey would ask both yes or no questions, as well as provide the opportunity for written comments to a series of questions, such as "Would you like to compliment a particular staff member" and "if you could change anything…what would it be?"
• All the relatives we spoke with could name the manager, and had previous contact with them.

• Relatives' feedback included, "They do come from the office and any new people in the office come and introduce themselves. The owners do come out and introduce themselves and say that if there is anything they can do for us to let them know. I definitely feel the carers are happy in their job. They come in with a smile on their face and don't moan" and "I have had to call out of hours many times and the managers… they have given me their own private mobile numbers. For example, last time I had to call at 11pm and she [the manager] answered and was able to tell me how to manage [an issue]."

Continuous learning and improving care:
• After our last inspection, the provider registered with the Information Commissioner's Office, as required. This was because the service processes and stores confidential personal information.
• The service did not have robust measures in place to ensure that there was learning from incidents or issues.
• There were medicines administration record (MARs) chart audits dated September to November 2018. These showed the service checked for completion of the chart, missed signatures, ceased or started medicines, if any errors needed to be reported and so on.
• The audits did not correspond with our observation of the MARs. We found improvements were required, but the service relied on the compliance consultant's assessment to determine that changes were required. The provider had enough time after our last inspection and report to implement changes to ensure good care.
• Daily log audits dated September to November 2018 were completed. Notes were checked for legibility of handwriting, whether the records were signed, dated and had the time recorded, whether there were any issues that required further investigation and whether there were any actions required to assist the support package.
• Although staff completed the notes at each call, the quality of the content required improvement. Staff recorded tasks they completed, and not holistic information about the person such as their mood, how they interacted with the person or any feedback provided. The audit results did not reflect this.

Working in partnership with others:
• The service continued to work effectively with relevant community stakeholders. This included the local authority.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person failed to effectively assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.